



State of New Jersey

DEPARTMENT OF HEALTH AND SENIOR SERVICES

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www.state.nj.us/health

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120 South Stockton Street, Lower Level  
Trenton, NJ 08611-1730

**Use the Physical Address for DHL, Federal Express, or UPS**

TO: Nurse Aide Training and Competency Evaluation Programs (NATCEP)  
FR: Henry T. Kozek, RPh, MPA, CPM - Program Manager, Certification Program  
RE: Instructor Training Workshop and Evaluator Training Workshop

**October 1, 2004, Instructor Workshop.** Registration begins at 8:00 a.m.; workshop ends at 4 p.m.

**November 17, 2004, Evaluator Workshop.** Registration begins at 8:00 a.m.; workshop ends at 4 p.m.

**REQUIREMENTS:** 1. Be currently licensed as a registered professional nurse; 2. Possess at least three (3) years of full-time or full-time equivalent experience in a health care facility; 3. Possess at least one (1) year of full-time or full-time equivalent experience as a registered professional nurse in a licensed long term care facility within the five (5) years immediately preceding submission of resume to the Certification Program of the Department for approval. 4. Current affiliation with a Department of Health and Senior Services approved NATCEP.

**Each resume SHALL include:** 1. Instructor's name; 2. Instructor's home mailing address; 3. Current NATCEP affiliation; 4. Previous employment (start with position just prior to the NATCEP affiliation and work backward); 5. Exact month and year (start date and termination date) of each position; 6. Indicate if each position is full-time or part-time (if the position is part-time, the specific number of hours per week must be indicated); 7. Title of each position; 8. A BRIEF description of the duties of the positions listed; 9. Name of nursing school and exact month and year of graduation from nursing school. Your **current license (not a copy) must be brought to the Workshop.** **DO NOT** submit the original or a copy of your license to this office prior to the Workshop.

The cost is \$25.00 per attendee for **EACH** workshop and a check must accompany this registration form. **Please make check payable to: New Jersey Department of Health and Senior Services.**

Please note that the workshop is filled on a first come first served basis and may reach capacity prior to date of workshop. Upon our approval, a confirmation notice along with appropriate instructions and directions will be mailed to the attendee's home address a week before the workshop. **Please ensure that the information in paragraph 2 is on the resume.** You may photocopy this notice. **PLEASE DO NOT FAX.** Please detach the bottom portion of this form, attach it to your resume, and send to the Certification Program. **PLEASE REGISTER SEPARATELY FOR EACH WORKSHOP.**

Registration Form - Instructor Workshop – 10/1/04 \_\_\_\_\_ **INCLUDE RESUME (SEE ABOVE)**  
Registration Form - Evaluator Workshop – 11/17/04 \_\_\_\_\_ **INCLUDE RESUME (SEE ABOVE)**  
Name \_\_\_\_\_  
School or Nursing Home Affiliation \_\_\_\_\_  
Daytime telephone number (include area code) \_\_\_\_\_  
E- Mail Address \_\_\_\_\_